**VISION EXAMINATION REPORT TO OBTAIN A CONNECTICUT OPERATOR'S LICENSE**
**B-291 REV. 5-2001**

STATE OF CONNECTICUT
**DEPARTMENT OF MOTOR VEHICLES**
*BRANCH OPERATIONS DIVISION*
On The Web At http://dmvct.org

## ELIGIBILITY FOR COMPLETING THIS FORM

**This form may be used only if the applicant meets the following visual standards:**

1. A minimum visual acuity of 20/40 (Snellen) or equivalent binocular visual field or monocular visual field with or without corrective lenses;
2. An uninterrupted binocular visual field of at least 140° in the horizontal meridian, or a monocular field of at least 100° in the horizontal meridian; and
3. No other visual condition(s) which either alone or in combination will significantly impair driving ability.

## INSTRUCTIONS FOR COMPLETING THIS FORM

1. Visual examinations may only be conducted by, and this form must be completed by, a licensed Physician, Ophthalmologist, Optometrist, or Registered Nurse.
2. PRINT in ink or TYPE all information in the boxes indicated.
3. Be sure to enter the patient's *(applicant's)* name exactly as it appears on the operator's license application.
4. Have the patient *(applicant)* sign his or her name in the space indicated.
5. Complete ALL the boxes on this form.
6. Give this report to the patient *(applicant).* **DO NOT MAIL THIS REPORT.**

**NOTE: This report is not valid unless test is given within three (3) months of license application.**

**NAME OF PATIENT** *(Last, First, Middle Initial)* | **DATE OF BIRTH** | **SEX** ☐ **MALE** ☐ **FEMALE**

**PATIENT'S RESIDENCE ADDRESS** *(Number and Street)* *(City or Town)* *(State)* *(Zip Code)*

**BEST VISION TEST SCORE (SNELLEN) WITH OR WITHOUT CORRECTIVE LENSES**

| *RIGHT EYE* | *LEFT EYE* | *BOTH EYES* |
|---|---|---|
| | | |

Did the patient wear corrective lenses to achieve a Snellen Test score of 20/40 with one or both eyes? ☐ **YES** ☐ **NO**

**IF YES, PLEASE CHECK THE APPROPRIATE BOX**
☐ **No change in Prescription** ☐ **Revised Prescription** ☐ **Patient's First Prescription**

Extent of horizontal visual field? *(Indicate degrees)*

| 0 **RIGHT EYE** | 0 **LEFT EYE** | 0 **BOTH EYES** |
|---|---|---|

Presence of any medical blind spots? ☐ **YES** ☐ **NO**

Is there a visual condition present which is deteriorating or which would require a vision examination or visual screening on a regular basis? ☐ **NO** ☐ **YES****

**** IF YES, a report containing diagnosis or prognosis must be submitted to: STATE OF CONNECTICUT, DEPARTMENT OF MOTOR VEHICLES, MEDICAL QUALIFICATIONS UNIT, 60 STATE STREET, WETHERSFIELD, CT 06161-2525**

**SIGNATURE OF PATIENT** | **DATE SIGNED**

**X**

## EXAMINER INFORMATION

The patient described above has been examined by me and this report has been completed by me and is correct to the best of my knowledge and belief.

**NAME OF EXAMINER** | **TITLE OF EXAMINER** *(Check one)* ☐ Licensed Physician ☐ Optometrist ☐ Ophthalmologist ☐ Registered Nurse | **DATE OF EXAMINATION**

**EXAMINER ADDRESS** *(Number and Street)* *(City or Town)* *(State)* *(Zip Code)*

**SIGNATURE OF EXAMINER** *(Licensed Physician, Ophthalmologist, Optometrist, or Registered Nurse)* | **WORK TELEPHONE NUMBER** | **PROFESSIONAL LICENSE NO.**

**X**